MEDICAID BILLING REMITTANCE
AREA EDUCATION AGENCY

Provider NPI/ID: XXXXXXXXXX Invoice # XXXXXXXXXX Date XX/XX/XX

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

For the month of 07/10, your agency received $XXX.XX.

If you have questions or concerns please contact Steve Crew at steve.crew@iowa.gov or (515)281-6285. Thank you for your assistance.

cc: DHS, DE